Kenya APHIA Financing and Sustainability Project: Project Completion Report, July 2001

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APHIA Financing and Sustainability (AFS) Project
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Management Sciences for Health
165 Allandale Road
Boston, MA 02130
(617) 524-7799

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LIST OF ABBREVIATIONS

APHIA	AIDS, Population, and Health Integrated Assistance
AFS	APHIA Financing and Sustainability Project
CA	Cooperating Agency
COP	Chief of Party
COTR	Contracts Officer Technical Representative
DHCF	Division of Health Care Financing, Ministry of Health
DHMB	District Health Management Board
FP	Family Planning
GOK	Government of Kenya
JICA	Japanese International Cooperation Agency
KHCFP	Kenya Health Care Finance Project
LTTA	Long Term Technical Advisor (Resident in Kenya)
MSH	Management Sciences for Health
MOH	Ministry of Health
REDSO/ESA\	Regional Economic Development and Support Office/Eastern and Southern Africa
USAID/Kenya	United States Agency for International Development/ Kenya Mission

ACKNOWLEDGEMENTS

The accomplishments of the AFS Project are the result of a tremendous effort by all the counterpart organizations to the AFS Project, especially the Ministry of Health, and the consultants and technical advisors who worked on all aspects of the project. Primary thanks are to the Ministry of Health officials in senior management, the Division of Health Care Finance, the Training Division, Provincial Medical Officers, and hospital directors and staff. Particular thanks are reserved for the Director, Board, and staff of Coast Provincial General Hospital.

The USAID/Kenya mission has been very supportive of the AFS Project from its inception through completion, including making a special provision in the contract for documentation and dissemination. This report, the manuals and other project documents completed under the project, and the AFS Conference all reflect this priority that activities and lessons learned should be documented and shared with other organizations with similar challenges facing them.

The organizations that requested technical assistance from the AFS Project should receive the credit for the accomplishments cited in this report. Their work to improve services, increase revenues, reduce costs, promote sustainability, and above all make health services better and more affordable is described in the following chapters. Working with a wide range of organizations has stimulated innovation as well as success in the difficult and ongoing task of improving performance and services. These organizations have already started the process of collaboration and sharing of experiences and systems among each other. That process will certainly continue.

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Introduction

This completion report for the APHIA Financing and Sustainability Project (AFS) is the final report to USAID produced by the project. It summarizes the accomplishments of the project, the methods of work use, and makes recommendations regarding unfinished work and/or program continuation. The report is submitted in fulfillment of AIDAR clause 752.7005 of the USAID Contract No. 623-0264-C-00-7005 with Management Sciences for Health, Inc.

Background

Government health services decreased in quantity and quality throughout the 1980s. Nongovernmental organizations, though committed to the poor, could not increase their services sufficiently to supplement declining government services. While the private health sector grew in response to increasing demand, it was directed toward those with means, not the poor.

The administration of health services in Kenya was gradually decentralized starting in the mid-1980's with the establishment of a semi-independent government corporation to run Kenyatta National Hospital and with the creation of District Health Management Boards to administer the cost-sharing program at the local level. In 1997, the Ministry of Health also established boards for the MoH hospitals. Through these changes, the health system is gradually decentralizing, although more legal steps are required to formalize decentralized decision making. As a result of these changes, the AFS Project conducted much of its work at the provincial and hospital level, in close collaboration with the senior management of the MoH and the Division of Health Care Financing.

The APHIA Financing and Sustainability Project (AFS) was a complex US$7.5 million technical assistance contract between USAID and Management Sciences for Health, Inc., Boston. USAID and MSH signed the project contract in December 1996, and project field activities in Kenya began in February 1997.

To address the growing gap between health needs and health services, the AFS Project and the Ministry of Health worked to strengthen and expand services in the public, private, and nongovernmental sectors. Through a health reform model that targeted all three sectors of the national health system, they expanded and improved the services available throughout Kenya.

The project had four major components:

- Supporting the public-sector cost-sharing program;
- Improving health financing in the private sector;
- Increasing the sustainability of nongovernmental organizations that provide family planning services;
- Ensuring a reliable public-sector supply of essential drugs and family planning.

- In addition, a fifth component on documentation of project materials and dissemination of results was included in the project resources.

Objectives

The two-fold objective of the APHIA Financing and Sustainability Contract was to increase financial resources for health and family planning services in Kenya and the organizational capacity and self sufficiency of selected health and family planning service providers.

Accomplishments

From 1989 to 1995, Management Sciences for Health (MSH) worked closely with the Kenyan Ministry of Health to improve health services, through the five-year Kenya Health Care Financing Project, funded by the US Agency for International Development (USAID). Together, MSH, USAID, and the Ministry of Health built on that project's achievements through a second five-year effort: the **A**PHIA **F**inancing and **S**ustainability Project (AFS Project). From 1996 to 2001, the AFS Project engaged partners from the public, private, and nongovernmental health sectors throughout the country to strengthen and expand health care services.

The results emerging from more than a decade of experience show that significant improvements in health services can occur even during periods of economic decline and increasing morbidity. These successes can serve as models for other countries or organizations undertaking reform projects under similar circumstances.

The many accomplishments of the AFS Project are complex and difficult to summarize. They are discussed in detail in the Project Monograph, "Heath Financing and Reform in Kenya", [1] as well as a shorter summary "Success Stories: Initiatives In Health Care Financing: Experiences From Kenya".[2]

Ministry of Health

Cost-Sharing Program

By the end of the project, national cost-sharing revenues for health care services are at their highest level ever. They more than doubled between 1997 and 2000, from Ksh200 million to Ksh554 million. Project line-item expenditures booked to the end of June 2001 totaled over US$7 million. Fifty eight percent of those expenditures (over US$4 million) were directed towards the MoH Health Care Financing Program, covering all MoH hospitals and health centres in Kenya. This generated revenues of over US$23.5

[1] C. Stover, "Discussion Draft: Health Financing and Reform in Kenya: A Summary and Assessment of the Major Accomplishments of the APHIA Financing and Sustainability (AFS) Project: December 1996-June 2001" (Management Sciences for Health, AFS Project. May 2001). 147 pp.
[2] "Success Stories: Initiatives in Health Care Financing: Experiences from Kenya" (Management Sciences for Health, AFS Project. April 2001). 22 pp

million in the same period. The return on USAID's investment in MSH technical assistance from the AFS project is almost 6:1, indicating the immense leverage the project had in this critical area of health care financing.

HIGHLIGHTS OF AFS PROJECT ACCOMPLISHMENTS

❖ Supporting the public-sector cost-sharing program;

- Since 1997, revenues have more than doubled, from 200 million KSh ($3 million US) to over 550 million KSh ($7 million US). These revenues have supplemented declining government revenues and supported significant improvements in the quality of health services.
- Between 1998 and 2000, the AFS Project introduced networked cash registers at Coast Provincial General Hospital. As a result of this and revised collection procedures, revenues from patient fees increased by 400%. Cash registers were then introduced into 14 other government hospitals.
- The cost sharing program is now self-sustaining without donor support. Training programs are in place, including pre-service training at the Kenya Medical Training College.
- Quality improvements at Coast PGH resulted from the re-engineering program supported by the AFS Project and capital improvements funded by JICA. Patient surveys showed that hospital services had improved tremendously. In 1998, only 47% of patients were satisfied with both inpatient and outpatient services; by March 2000 this had increased to 88%.

❖ Improving health financing in the private sector;

- Standardized treatment protocols developed at the Aga Khan Hospital reduced the cost per admission in the pediatrics unit decreased by an average of 36%.
- Similar work in assessing hospital admissions determined that 30% of the days spent by patients at Aga Khan Hospital were avoidable.
- Many of the techniques to improve quality and reduce costs from the work with the Aga Khan Hospital has been successfully introduced at Coast PGH.
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❖ Increasing the sustainability of nongovernmental organizations that provide family planning services;

- PCEA Chogoria dramatically improved its level of managerial and financial self-sufficiency. By controlling outside ventures operating at a loss and restructuring the clinics, PCEA Chogoria made clinical care more efficient, cost-effective, and independent.
- Additionally, it established cash collection methods and installed a comprehensive hospital management information system to improve management in each department.

The project implemented a strategy of functional decentralization of program management that was designed to achieve the objectives and targets of the project. Furthermore, the project recognized that health-financing policies developed in the early 1990's were still valid, but not fully implemented. It was believed that revenue growth would be achieved by improving local program management, and so the project focused on four key areas of intervention.

- ❖ *Nationwide Training in Program Management*
- ❖ *Installation of Cash Registers*

- *Development of Monitoring Systems*
- *Hospital Management Development*

Nationwide Training in Program Management

To promote future sustainability of the Cost Sharing program, the USAID-funded AFS project developed a training strategy with a provincial focus. This identified the need to develop a cadre of trainers at both provincial and district levels, and to install pre-service training at the KMTC. A Project Training Officer was hired in 1998, a set of curricula was developed with extensive input from the MoH, and a major nationwide training program was initiated. A complete set of curricula comprising Master Training Manual, Training of Trainers for Cost Sharing and Facilitation Skills Guide was prepared by the project.

The AFS Project also trained 30 lecturers at the Kenya Medical Training College and transferred responsibility for the pre-service training curriculum to the college. The first class trained in administering the cost-sharing program was trained in January 2001. This should mean more program managers are billing patients at the right time, handling waivers and exemptions properly, and billing insurance companies promptly. The college and the Ministry can use the curricula without further technical assistance.

Using the new modular curriculum, the training targeted a critical mass of hospital management team members as well as District Treasury officials in all the districts across the country. The training plan, spanning 15 months, was conducted and completed successfully in June 2000. A total of 632 staff has received one week intensive training in Cost Sharing under this program. Additionally, a total of 330 medical records, clerical and accounts staff from all the eight provinces have been trained in the new Financial Information System for Cost Sharing.

Most of the training courses were held either on-site (within hospitals) or using low cost alternative venues that conform to MoH financing capabilities.

In June 2000, the MoH Permanent Secretary issued a circular to all Provincial Medical Offices instructing them to finance the training of MoH staff in the management of the cost-sharing program from resources generated by the program itself. The program is now poised to be managerially self-sustaining, with a solid training program generating increasing revenues that can be used to sustain further management training.

Installation of Cash Registers

One weakness of the cost-sharing program involved the use of handwritten receipt books to account for patient fees. By installing cash registers, it was hoped that losses could be stemmed and revenues increased.

Coast Provincial General Hospital (PGH) in Mombasa is the second largest government hospital in Kenya, serving a population of 500,000. The MoH selected Coast PGH for AFS assistance because of its size, need for improvements, and a plan to prepare it for autonomous status. Due to declining government support for public hospitals, by the early 1990s Coast PGH relied increasingly on revenues from the cost-sharing program. However, the traditional fees collection method using manual receipt books permitted clerks to under report or steal collections and made it hard for patients to verify their bills.

To better control fee collection, the AFS Project helped Coast PGH introduce networked cash registers. These cash registers immediately:

- reduced losses from the manual cash receipt system;
- increased cash revenues at the hospital;
- improved the efficiency, cost-effectiveness and accuracy of cash accounts;
- reduced the administrative delay in producing reconciled accounts of cost-sharing revenues;
- enabled patients to keep better records of their hospital expenses.

An important component of the Coast PGH cash register program was the decision to purchase the cash registers within Kenya. As a result, the hospital has not had to rely on foreign assistance to install or maintain the system.

The hospital and the project installed cash registers at five key points: the emergency room, pharmacy, laboratory, maternity ward, and the National Hospital Insurance Fund's office. These points were selected due to their high volume of transactions, and their suitability for networking in the physical layout of the hospital.

- The units were linked as a network and supported by a computer server.
- The cash registers operated like those used at supermarket checkouts.
- The receipts issued and recorded by the registers had a printed description of every item paid for, the amount of money paid, and the amount of change given.

The registers had cash drawers so that the money collected could be held securely and accounted for.

Within a month of installation, average daily cash collections almost doubled, to 70,000 KSh ($900 US) per day, reaching a monthly peak of over KSh 2 million ($26,000 US) by the end of September 1998. Overall, cash registers increased monthly revenues from 1.2 million KSh ($16,000 US) in July 1998 to 6.5 million KSh ($84,000 US) in December 2000.

A survey of Coast PGH staff indicated that the cash register system has benefited patients and increased patient satisfaction. One staff member noted that patients no longer complained about being coerced into making under-the-table payments.

The success of the cash registers program at Coast PGH shows the drastic increase in revenue that can occur when an institution changes from a manual to a mechanized collection system. As at Coast PGH, this can enable the hospital to make much-needed improvements to its facilities and services. The experience at Coast PGH also illustrates the importance of continuous management attention. For example, after cash registers were installed, changes were required in the collections staff, improved systems for recording charges for services were instituted, and more of the charging and billing system was computerized.

Development of Monitoring Systems

Nationally, AFS installed a financial information system in the country's eight provincial medical offices, and at headquarters, for reporting to the Ministry on cost sharing revenues, expenditures, banking and health utilization statistics. The system provides essential information for oversight of the cost-sharing program, and is very useful for general management.

The new financial information system now provides Kenya's Ministry of Health with a broad, in-depth picture of the performance of the nation's cost sharing program and finances. And it gives Provincial Medical Officers the information they need to oversee and supervise the expenditures of cost sharing revenues. The system provides performance information on revenues, money banked, approved expenditures, money spent, and both outpatient and inpatient utilization statistics at all cost sharing facilities. It is linked by regular data transmission with the Division of Health Care Financing (DHCF) at MOH in Nairobi.

A locally hired consultant worked with DHCF and provincial staff to redesign the existing system to provide greater flexibility and more complete information. Staff critique and subsequent training followed testing at Coast Provincial General Hospital in July 1999. Clerical staff was trained in basic computer skills, then on the system itself. Since installation, there have been nine software upgrades. AFS also installed modems and e-mail accounts in all provincial medical offices and at HQ. Now, Provincial Medical Offices, the Division of Health Care Financing, and the offices of the Permanent Secretary and Director of Medical Services have financial information at their fingertips.

Before the financial information system was in place, cost-sharing revenues and expenditures were not tracked effectively, and because all data were compiled at HQ, it was the central Ministry that approved all expenditure decisions. The new system gives Provincial Medical Officers the information they need to manage the money. They have been delegated the responsibility to authorize expenditures, which greatly reduces the time required for approvals and means that the expenditure of cost sharing monies on service improvements is much faster than ever before. The system has other benefits also:

Decentralized management

With data management decentralized to the Provincial Medical Officers, data collection and entry are one big step closer to those who use information for day-to-day program

management. This has removed the need for frequent supervisory visits to provincial hospitals by MOH officials, and has made it easier for the HQ DHCF to focus its resources on oversight and troubleshooting of the cost-sharing program. For the first time, every province is connected with headquarters by email.

Better use of information for management
In the two years the system has been up and running, the level of information use at the provincial level has increased dramatically, from clerical staff to the Provincial Medical Officers. Part of the reason the system has been so successful is that it has become a part of Ministry procedures, and staff have become increasingly knowledgeable about how to make it work for them.

Building local capacity
In addition, AFS and the consultant concentrated on creating capacity within the DHCF to support the system. All day-to-day operations and support of the system have been managed entirely by Ministry of Health personnel since February 2000. The only outside support has been programming upgrades.

Simple modular approach
The modular system is simple and flexible. It can grow with the desire and need for more information just by adding additional reporting modules. The system was set up with a small budget, and it works.

Regular review by users
System users meet twice a year to discuss problems with the system and request new features. Some provinces are beginning to extend use of the information to the district level. In Coast Province, for example, all district hospitals now have computers, and they are now getting quarterly feedback reports based on the information they submit, via e-mail. A next step would be to connect district hospitals into the financial information system, so that they can input information directly and make use of the information themselves.

Hospital Management Development

The increased revenues at Coast PGH due to cost sharing allowed the hospital to focus on much-needed improvements in its facilities and services. It asked the AFS Project, in partnership with the Japanese government, to help assess its services and assist in planning and overseeing its physical renovations and service improvement initiatives.

The first step in improving the hospital's services was to strengthen clinical practices and management. The AFS Project conducted an organizational assessment and a community survey to determine Coast PGH's strengths and weaknesses. It used the results to streamline the management reporting structure, develop an action plan, and implement steps to increase revenue. Simultaneously, the Japanese government provided funding and support for the physical renovation of hospital facilities.

The joint efforts of Coast PGH, the AFS Project, and the Japanese government have resulted in significant improvements in the hospital's facilities and services, including:

- re-opening the maternity unit, operating rooms, and intensive care units;
- training the hospital board of directors;
- reorganizing senior management;
- improving nursing services;
- organizing the medical staff to take initiative and responsibility for its own management;
- renovating and reorganizing the emergency room.
- Increasing revenues fourfold by introducing computerized cash registers

To measure the impact of its work at Coast PGH, the AFS Project conducted quality-of-care assessments among patients. Patient surveys showed that hospital services had improved tremendously. In 1998, only 47% of patients were satisfied with both inpatient and outpatient services; by March 2000 this had increased to 88%.

The work at Coast PGH demonstrates that it is possible, with planning, long-term commitment, and the necessary resources, to "turn around" a large government hospital, resulting in drastic improvements in the hospital's services. The program at Coast PGH has laid the groundwork for similar improvements at other large health facilities in Kenya and throughout Africa.

Private Sector

Clinical Pathways

The mission of Aga Khan Hospital, a private, non-profit organization, includes outreach to the poor. The hospital asked the AFS Project to help it improve its health services for low-income patients. For the hospital to reach its goal—offering a general health care program to a greater number of patients, and introducing low-cost, fixed-price packages for maternity, pediatric, and simple surgical services—it first needed to improve its cost management and the efficiency of its services.

The AFS Project worked with a multidisciplinary team, and prioritized the following areas:

- limiting the excessive use of costly drugs and laboratory tests;
- maximizing the quality of drugs and laboratory tests;
- creating guidelines for standardized treatment regimens to increase efficiency;
- developing a manual for use in other health care facilities to standardize service delivery and management practices.

Before standardizing treatments hospital wide, the AFS Project worked in the pediatrics unit to develop clinical pathways, or standard treatment guidelines, for the four most

common pediatric illnesses: upper respiratory infection, lower respiratory infection, malaria, and gastroenteritis. By standardizing treatments, the hospital hoped to decrease the amount of time spent by health care providers per case, and to increase the use of the most cost-effective medications.

Instead of bringing in outside consultants, the AFS Project worked with the hospital Care Management Department, who involved hospital doctors, nurses, and pharmacists in developing standardized treatments in the pediatrics unit. Having been involved in developing these guidelines, the staff enthusiastically applied them to their patient cases. After only a few months, the cost per admission in the pediatrics unit decreased by an average of 36%.

Aga Khan Hospital is now using its success in the pediatrics unit as a model to develop protocols throughout all departments. By increasing efficiency and cutting costs, the hospital ultimately hopes to be able to offer improved services to a greater number of low-income patients, helping to fulfill its mission to serve the poor.

Admission & Discharge Screening

In 1999, as part of Aga Khan's initiative to increase efficiency and improve its services for the poor, the AFS Project began working with the hospital to analyze its average inpatient hospitalizations, to determine whether hospitalizations were necessary and of appropriate duration.

To analyze hospitalizations, the AFS Project used a tool developed in the US, which establishes criteria for hospital admissions and length of stay. The tool can be used retroactively, to determine whether the admission of a particular patient was actually necessary, and if so, if the length of the patient's stay was appropriate.

Through the use of this evaluation tool, the AFS project judged that 30% of the hospital stays at Aga Khan Hospital were unnecessary. With this critical information, the hospital can now act to reduce unnecessary admissions, at a huge cost savings. In the US, for example, the use of such monitoring systems since the 1970s has decreased hospital admissions by roughly 40%.

While the use of the monitoring tool is in its early stages at Aga Khan hospital, this monitoring and evaluation is a critical step in decreasing unnecessary costs and improving services. The early success of this initiative demonstrates that tools used in the private sector in the US can be applied in other countries' private sectors with exceptional results—no matter how different their health care systems may be.

Improving the Sustainability of Health/FP NGOs

Since the late 1980s, USAID and other donors have collaborated with organizations in the nongovernmental sector of Kenya to improve the country's health services. The many factors contributing to problems in the health sector have proved difficult to overcome, and many organizations remain heavily dependent on donors for their ongoing operations. A critical goal for many of these organizations is to become more sustainable without donor assistance.

Improving financial sustainability at Chogoria hospital

The Chogoria Hospital network, operated by the Presbyterian Church of East Africa (PCEA Chogoria), includes a 300-bed main hospital; a community health department; groups of community volunteers; a nursing school; and several non-health related projects. The community health department is comprised of a family planning/maternal health clinic on the hospital grounds and 30 rural community clinics.

In the past few years, a steady decline in the utilization of the hospital's inpatient and outpatient services, coupled with rising costs, forced the hospital to increase prices steadily. This has contributed to further reduction in utilization, causing the hospital to run deficits and threatening its ability to continue operations, even with outside assistance.

The AFS Project provided technical assistance to PCEA Chogoria Hospital to help increase its managerial and financial self-sufficiency. Its work proceeded in three phases:

The first phase: The AFS Project assessed PCEA Chogoria in detail, including conducting cost and revenue analyses of its major programs. Analyzing the hospital's services and costs helped it identify where it was losing money and how it could increase revenues. The hospital found that it was losing money through its non-core businesses: a gas station, a restaurant, and a guesthouse.

The second phase: PCEA Chogoria sold or leased its non-core businesses to the private sector to operate, in order to focus on improving its core business as a hospital.

The third phase: With the AFS Project's assistance, PCEA Chogoria focused on improving its performance by:

- identifying weaknesses in management, particularly the pricing of services;
- designing a computerized management information system for tracking and forecasting financial and other data;
- strengthening departmental planning, monitoring, and development.

With the help of the AFS Project, PCEA Chogoria dramatically improved its managerial and financial self-sufficiency. By controlling money-losing outside ventures and

restructuring the clinics, PCEA Chogoria took critical steps to make clinical care more efficient, cost-effective, and independent. Additionally, it established critical cash collection methods and installed a comprehensive hospital management information system, to ensure the ongoing maintenance of financial and management systems. Most importantly, PCEA Chogoria laid the foundation for the next step: essential and far-reaching quality improvement initiatives.

Motivating staff to improve services at Chogoria clinics

In 1997, the PCEA Chogoria network was forced to subsidize 18 of its 30 rural clinics because they cost more to run than they collected in revenue. The network asked the AFS Project to help address its financial imbalance. A pilot project, which rewarded clinic staff for improved services and increase revenue, reversed the economic decline at every clinic where it was introduced during the trial period.

The AFS Project's initial assessment had suggested that the clinics' poor financial performance was caused by internal factors such as inadequate services, rather than by insufficient demand by the population or other external factors.

Focusing on internal factors within its control, PCEA Chogoria management first addressed staff motivation and performance. Initially, the salaries of rural clinic staff were not tied to any measure of productivity, the clinic's financial status, or client satisfaction. To increase both staff and clinic performance, management linked staff compensation to clinic performance. The network chose revenue as the measure of staff performance. Since all patients pay clinic fees, revenue is a strong indicator of the number of patients served. An increase in revenues reflects an increase in patient visits, which reflects an increase in satisfaction with the clinic. The productivity rewards system gave clinic staff a bonus for the months that their clinic achieved an increase in revenue.

The performance incentives pilot was conducted at selected clinics from November 1998 through April 1999. During the test period, the six pilot clinics moved from a net financial loss of 108,458 KSh ($1,400 US) for the six months before the test to a net gain of 37,630 KSh ($488 US). In clinics where no performance incentives were introduced, net revenues decreased during this same period.

While financial incentives are common in the private for-profit sector, they can also be applied effectively in public and nongovernmental organizations. The Chogoria pilot provides a good example of how a financial incentives system can improve performance, even in rural health care settings, if the system is regularly monitored.

Ensuring a reliable public-sector supply of essential drugs and family planning commodities

The work of the AFS Project focused on a comprehensive assessment of the systems of financing, procuring, and distributing essential drugs and family planning commodities. Upon completion of this assessment, USAID and the MoH agreed that further work in this area would be carried out by other CAs, and the proposed drug quantification study would be postponed indefinitely.

Documentation and Dissemination

The final component of the AFS Project was a major emphasis on documentation of the Project's work and dissemination of relevant materials and lessons learned within Kenya and in other countries. The project produced several key documents that summarize AFS's work and lessons learned:

- *Health Financing and Reform in Kenya: Lessons from the Field*, a detailed analysis of the AFS project by Charles Stover;
- *Initiatives in Health Care Financing: Experiences from Kenya*, a shorter document highlighting the project's successes;
- Bi-annual *Contractor Self-Evaluation Reports (CSER)*, clear, detailed accounts of project activities submitted to USAID, and
- Quarterly reports on Project Activities during the quarters when CSERs were not submitted.

The draft monograph, "Health Financing and Reform in Kenya" provides a detailed review and assessment of the major elements of the AFS work with partner organizations. It serves as the basic reference document for other analyses and documentation, and cites most project documents as sources. The shorter and more high level "Initiatives in Health Care Financing: Experiences from Kenya" has been produced in larger quantities and is widely circulated. Both are accessible through the MSH Bookstore, and through the MSH Website.

The AFS Project also held an end-of-project conference in Nairobi on May 22-24, 2001. This conference focused attention on the accomplishments of the AFS partner organizations. 120 participants, mostly from Kenya, shared their experiences, viewed live systems demonstrations, and discussed ways to further disseminate and continue their work. The MSH Website, msh.org, also publicized the conference in advance and afterwards by posting the agenda, proceedings, findings, photos, etc. as a special feature. In addition, the MSH Electronics Resources Center has posted several of the key documents in a format that can be downloaded over the Internet. Information from the conference was sent to several hundred interested individuals and posted on many major List Serves. As a result, most of the AFS Project work is easily available to interested individuals and organizations anywhere in the world.

Methods of Work

Sustainable Local Resources

An important component part of the AFS approach to sustainability was to use local resources wherever possible. This was to ensure that work carried out during the life of the project could be supported one the project ends. This approach has work extremely well, and there will not be a lingering dependence upon expatriate technical assistance at the end of the contract.

The 13-member long-term team consisted of nine Kenyans and three to four expatriates. Only one expatriate, the Chief of Party remained throughout the life of project. Throughout the contract, local consultants outnumbered international consultants by a factor of 2:1, and all local subcontracts were awarded to Kenyan firms.

An extensive database of local technical resources was developed by the project, and it was from this database that many consultants were recruited.

Cross-Sectoral Partnerships

Engaging partners from every sector, the AFS project applied the same set of guidelines to its work with each sector. These guidelines included:

- Establishing an agreement or contract clarifying the work for which each party was responsible;
- Applying a management assessment tool to identify the most critical management needs of each organization;
- Sharing training programs among different organizations, so that tools or approaches successfully developed for one organization or sector could be disseminated among others.

The project had a deliberate policy of working with institutions where a high probability of success was anticipated, and then once changes had been made and successes registered, other institutions were encouraged and were assisted in learning from the successful institution.

A case in point is Coast PGH. The success of the cash registers there was used to assist fifteen other hospitals learn how to improve revenues using these systems. At the Aga Khan Hospital the success with paediatric treatment protocols spurred Coast PGH to repeat the exercise. And at Chogoria, the success with the HMIS encouraged Coast PGH staff to upgrade their systems.

Production of practical tools and manuals

A combination of local consultants, MSH experts, and staff from participating organizations have collaborated in developing and applying the tools developed by the project. Since staff were trained and involved in the application of these tools, many of the organizations involved in these diverse areas now have the capacity to manage these tools themselves.

The AFS Project used three tools developed by MSH to analyze the costs of services at both the clinic and the hospital level, and one survey instrument for measuring quality in hospitals:

- Cost Estimate Strategy (CES)
- Cost and Revenue Analysis Tool (CORE)

- Hospital Costing Tool
- Quality Measurement Survey

Cost Estimate Strategy (CES): A spreadsheet-based tool, CES helps hospitals determine what drugs and supplies they need for their patient populations. CES helps hospital staff:
- identify essential drugs and supplies and establish prices for them;
- analyze and compare the prices of standard treatments;
- develop lists of essential drugs and supplies to monitor their availability;

Cost and Revenue Analysis Tool (CORE): CORE allows a hospital or clinic to compare the costs of and revenues for its services. Each service is analyzed in terms of the staff time, clinical supplies, medicines, and other supplies that it uses. CORE can help clinics to:
- improve the efficiency of their services;
- expand services;
- integrate new services into existing operations;
- increase financial sustainability.

Hospital Costing Tool: The Hospital Costing Tool is similar to CORE, but can be used in more complex settings. The tool helps hospital administrators to:
- measure the performance of different wards or units;
- evaluate supply costs;
- compare revenues with costs;
- link unit costs to quality measures;
- compare costs with those of other hospitals.

This information can be used for making decisions about current expenses and revenues. It can also be used for planning, such as making cost projections and budgeting.

Quality Measurement Survey: The Quality Measurement Survey helps evaluate quality in a hospital. MSH developed the tool to measure quality for a hospital accreditation process, and linked accreditation to a reimbursement program as an incentive to hospitals to improve their services.

Teams of local consultants, MSH consultants, and staff from participating organizations have collaborated in applying the costing techniques in various organizations. Since the organization's staff are trained and involved in the application of these tools, many of the organizations involved in costing activities now have the capacity to manage these costing tools themselves.

Because the costing exercises require the participation of both clinical and financial staff in each institution where costing took place, they established a cooperative dialogue between these two groups and helped improve communications over all. While the costing tools do not, in themselves, ensure good management, high quality, or effective

leadership, they do allow organizations to better understand their cost and service delivery structures and how to collaborate to make constructive changes.

The AFS Project also developed many manuals that are useful within Kenya as well as other countries. Several examples include: Hospital Board Manual, Hospital Operations Manual, By Laws for Medical and Dental Staff Organizations, Cash Register Procurement and Operations Manual, and Manual on Development of Clinical Pathways to Improve Clinical Services. These manuals are also available through MSH is PDF Format. The USAID-funded MSH Health Reform Project in the Philippines has already adapted the Hospital Board Manual for use in Philippines government hospitals.

Close institutional relationship with Ministry of Health

The project, like its USAID-supported predecessor, the Kenya Health Care Financing Project, was located in the offices of the Division of Health Care Financing of the Ministry of Health, and from the first day of project activities in Kenya, the head of that division acted as counterpart to the chief of party--as was the case in the last project. Where required by the contract, the MoH counterpart provided approvals from the Ministry of Health for the implementation of project activities.

Project activities were carried out in accordance with the provisions of the contract. Annual activity plans, which are contract deliverables to USAID, were prepared with the fullest possible participation of MoH officials and other stakeholders. The project also held regular monthly meetings with DHCF staff and these meetings were used to guide and direct the implementation of each activity plan.

Regular quarterly activity reports were also prepared as well as biannual contractor self-evaluation reports of project activities. The latter were used by USAID to assess the performance of MSH in implementing the contract. In the second year of project activities, a set of carefully quantified Performance Targets and Indicators for the contract were approved by USAID. These provide the evaluation framework for the duration of the contract.

The contract was performance-based, and included an award fee. The award fee, along with the biannual Contractor Self-Evaluation Reports, kept the project focused on deliverables and results, and stimulated
in-depth review by USAID and the Ministry of Health.

Recommendations

No five or ten year project can completely transform a struggling health system. The issues are too complex, the solutions too uncertain. But as the AFS Project's work in Kenya demonstrates, transformation can occur gradually, through achievements and improvements targeting one clinic, network of clinics, or health sector at a time. Over the past five years, despite measurable declines in economic, health, and social indicators in Kenya, the AFS Project and its partners in key organizations and the Ministry of Health

made significant progress in transforming Kenya's health system into one that provides adequate coverage for its entire population.

The technical work of the AFS Project benefited from the opportunity to work with all three sectors: public, nongovernmental, and private. The lessons it learned from this work can be applied in other initiatives in Kenya, as well as in similar work in many other countries.

RECOMMENDED APPROACH BASED ON AFS PROJECT EXPERIENCE

The AFS Project's approach, illustrated by the establishment of the cash register program in different sectors throughout Kenya, is recommended as an approach for other projects in health reform:

- identify problems in health financing through costing and other evaluation tools;
- work with the client organization to find practical solutions;
- monitor the results of the work;
- assess the success of the initiative, including areas that could be improved;
- adapt the findings and approach to other organizations and sectors.

Recommendations Regarding the Future of Health Reform in Kenya

Less is more

There is always a tendency for projects such as this to be overly ambitious, and to attempt too much and achieve too little. The extension of cash registers to 14 hospitals in one year was a case in point. In future, it would be better to focus on getting systems fully functional in a few sites before extending them elsewhere.

Quality

The quality of care in almost all health facilities in Kenya needs to improve. As cost sharing revenues rise, and become much more important sources of recurrent finance for the provision of care, .a particular focus needs to be applied to the improvement of clinical care. This is especially important in hospitals, which will have the greatest reliance on cost sharing revenues.

Clinical pathways

The use of clinical pathways to define appropriate diagnostic and treatment regimens needs to be extended to MoH facilities and linked to drug formularies and the forward planning of drug procurements using cost sharing monies. Infection control audits should be carried out in all major MoH hospitals and effective infection control programs put into place.

Equity

In 1999, the project proposed a major study of the effects of fee increases on access to health services in the public health sector, and on the operations of the waiver and exemptions systems. The MoH instead favored the extension of cash register to 14 hospitals and the study was not carried out. This study is long overdue, and after a decade of cost sharing in Kenya, it must be carried out. Draft terms of reference were developed and are available.

A strategy for continued success

The project's successes have been with the practical implementation of new systems in the field. Improvements to health financing mechanisms or the development of innovations are directly intended to improve the availability and quality of patient care. That does not happen at headquarters, and while there needs to be policy guidance and oversight, the project recommends that it should focus its very practical technical efforts on those institutions that are most likely to both benefit and succeed.

Support to the Division of Health Care Financing

The project recommends that the Division be staffed by a senior team with a level of qualifications and experience that will permit them to take charge of the cost-sharing programme and manage it effectively through existing Ministry institutions. This unit will also require logistic support. The lack of that support in 1995/6 was associated with a pronounced dip in national cost sharing revenues. The same may happen in 2001 if the hole left by the AFS project is not plugged. The level of support required to render the division functional is modest.

Facilitative Supervision of Provinces

The supervisory trips from headquarters should not extend beyond the PMOs offices. The supervision should move away from policing the systems to diagnosing problems and assisting to solve them through training and other forms of facilitative support. The new FIS will certainly play a central role in improving system performance. However PMOs and their staff need to learn how to use information for decision-making. Future technical resources should be used to this end.

PGH Management Development

It is impossible to be everywhere all at once, and given the moderately successful experience at Coast PGH, the project anticipates that extending the management development program to two other large provincial hospitals makes a great deal of sense. They are by far the largest revenue earners for cost sharing, and where the greatest impact can be made.

Conclusions

It has been a rare opportunity for Management Sciences for Health to participate in health reform activities over an extended period- in this case- ten years. This decade of experience has yielded many achievements that are clearly useful for Kenya and also provide valuable insights for other countries and organizations.

Kenyan individuals and organizations provided invaluable assistance to the AFS Project. Because of their involvement and experience, the understanding, expertise, and skills needed to further health reform and improvement initiatives still reside in Kenya. For progress to continue, the AFS Project's legacy must be built upon and expanded by the individuals and organizations with which the project worked. These individuals and organizations are the nation's greatest resources.

Many of the most significant policy and political decisions are whether to speed up the pace of reforms to allow health care providers in all sectors to meet the massive and complex challenge of treating AIDS on an inpatient and outpatient basis, as effective medicines become available at affordable prices. How can these health care resources be most effectively mobilized? Will speeding up the pace of reforms make the institutions more effective? Might a slow and measured pace of reform achieve more than a faster pace could? Will more effective decentralization of financial and managerial decision making cause real problems, or will it free hospital and district boards and teams to more effectively address the health care issues they face?

Given Kenya's economic and political circumstances, the future directions of reform of its health care system are uncertain. The next steps in health reform cannot be predicted and will be affected by many political, administrative, epidemiological, and health care system decisions. However, this uncertainty is not a valid reason for postponing current reforms, the expansion of the AFS Project's successes, or the launch of new health initiatives. There is never a perfect time for reform and improvement. The best time is nearly always the present.

Appendix A: List of AFS Project Documents

APHIA Financing and Sustainability Project

Catalog of Project Documents

Date	Author(s)	Type	Title
Oct-00	Adano		Pre-service/ KMTC training manual
Oct-00	Adano		Ummuro's Final Report (exit)
Apr-97	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, January 1-March 31, 1997
Apr-97	AFS Project	Quarterly Report	Quarterly Report, January 1-March 31, 1997
Apr-97	AFS Project	Activity Plan	Interim Activity Plan: April-December 1997
Jul-97	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, April 1-June 30, 1997
Oct-97	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, July 1-September 30, 1997
Oct-97	AFS Project	Quarterly Report	Quarterly Report, July 1-September 30, 1997
Dec-97	AFS Project	Activity Plan	Activity Plan 1998: December 1997-December 1998
Jan-98	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, October 1-December 31, 1997
Jan-98	AFS Project	Quarterly Report	Quarterly Report, October 1-December 31, 1997
Feb-98	AFS Project	MOU	Memorandum of Understanding-Mkomani Clinic Society (MCS)
Mar-98	AFS Project	MOU	Memorandum of Understanding- Family Planning Association of Kenya (FPAK)
Apr-98	AFS Project	Quarterly Report	Quarterly Report, January 1-March 31, 1998
Jun-98	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-2 with Trans Business Machines, Ltd: Network Cash Registers, Coast PGH
Jul-98	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, January 1-June 30, 1998
Aug-98	AFS Project	Flyer	Helping to get results: Installation of cash registers at Coast Provincial General Hospital
Oct-98	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-4 with Data Dynamics, Ltd: FIS
Nov-98	AFS Project	Activity Plan	Activity Plan 1999: December 1998-December 1999
Jan-99	AFS Project	Manual	Master Training Manual for the Cost Sharing Program
Jan-99	AFS Project	MOU	Memorandum of Understanding- Coast PGH
Jan-99	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, July 1-December 31, 1998
Feb-99	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-5 with Almaco Management Consultants, Ltd: FMIS, Chogoria Hospital and Coast PGH
Jul-99	AFS Project	Self-Evaluation	Extraordinary Report of Project Activities, July 23, 1999
Jul-99	AFS Project	Report	Operational Assessment of Three MOH provincial hospitals
Aug-99	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, January 1-June 30, 1999
Nov-99	AFS Project	Activity Plan	Draft Activity Plan 2000-2001: December 1999-December 2001

Dec-99	AFS Project	Manual	Training Manual for the Provincial Cash Register Implementation Team
Feb-00	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, July 1-December 31, 1999
Mar-00	AFS Project	Presentation	USAID Quarterly Review, July-December 1999
Mar-00	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-6 with Trans Business Machines, Ltd: Network Cash Registers, Moi Teaching and Referral Hospital
Apr-00	AFS Project	Quarterly Report	Quarterly Report, January 1-March 31, 2000
Apr-00	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-7 with Matra, Ltd: FMIS, Chogoria Hospital
May-00	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-8 with Trans Business Machines, Ltd: Network Cash Registers, Nyanza PGH
Jul-00	AFS Project	Self-Evaluation	Contractor Self-Evaluation Report, January 1-June 30, 2000
Jul-00	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-9 with Trans Business Machines, Ltd: Network Cash Registers, Rift Valley PGH
Jul-00	AFS Project	Presentation	USAID Bi-Annual Review, January-June 2000
Aug-00	AFS Project	Presentation	Helping to Get Results: Coast PGH (Presented to Duff Gillespsie, USAID)
Aug-00	AFS Project	Subcontract	Subcontract No. Kenya AFS/FP-FPLC-10 with Trans Business Machines, Ltd: Network Cash Registers, Kakemga PGH
Oct-00	AFS Project	Subcontract	Subcontract No. Kenya AFS- FP- FPLC 11 Nyeri PGH
Oct-00	AFS Project	Subcontract	Subcontract No. Kenya AFS-FP- FPLC 12 Embu PGH
	AFS Project	Report	MOH supervision of cost sharing program- DHCF supervisory tool
	AFS Project	MOU	Memorandum of Understanding- Chogoria Hospital
	AFS Project	MOU	AKH
	AFS Project	MOU	AAR
Apr-99	Almaco Management Consultants	Subcontractor Report	The Designed Financial Management Information Systems for Chogoria Hospital: Final Report
Apr-99	Almaco Management Consultants	Report	Design of the FMIS system for CPGH
Mar-98	Bates, Jim	STTA Report	Options for promoting financial sustainability of drugs, vaccines, and family planning supplies
Aug-99	Chandler, Rudolph	Report	Assessment of Five NGOs
Mar-97	Chesnais, Pia	STTA Report	To discuss contractual issues with the Chief of Pary and USAID
Oct-00	Clark		Hospital Operations Manual
	Clark, Jay	Manual	Handbook for Hospital Board Members
Jan-00	Clark, Jay	Workshop	Hospital Board Orientation/Training: Strengthening Board and Management Relationships
Oct-99	Clark, Jay and Silas Njiru, Ambrose Misori, Sam Munga	Report	Report of Hospital Operational Performance Assessment: Moi Teaching and Referral Hospital, Eldoret

Oct-99	Clark, Jay and Silas Njiru, Ambrose Misori, Sam Munga	Report	Report of Hospital Operational Performance Assessment: Kakamega PGH
Sep-99	Data Dynamics	Software	System User Manual: Financial Information System, MOH, Version 1.5
Feb-00	Data Dynamics	Manual	System User Manual: Financial Information System, Version 1.5
Mar-99	Data Dynamics	Subcontractor Report	System Design Document: Financial Information System, MoH
Aug-99	De'ak, William	STTA Report	Design the role and functions for the new post of Medical Director, AAR Health Services, on-going training and support to the development and implementation of a Utilization Management and Quality Assurance Program
Feb-98	Donaldson, Dayl	STTA Report	To conduct a cost and revenue analysis of the Mkomani project; Financial sustainability of the Mkomani project
Apr-98	Donaldson, Dayl and Samuel Kimani, Stephen Musau, Silas Njiru	STTA Report	To conduct cost, revenue, and utilization analysis of the Nandi Hill Tea Growers Association Dispensaries; Develop methodology for cost/utilization analysis in other centers; Train NHTGA staff in cost accounting methodologies, including CORE
Apr-98	Eichler, Rena	STTA Report	To determine the feasibility of converting Chogoria clinics into financially independent units and to assess various options
Oct-98	Eichler, Rena	STTA Report	To design a demonstration project to introduce financial incentives in Chogoria's clinics with the goal of improving staff performance and increasing revenue
Sep-99	Eichler, Rena	STTA Report	To evaluate the impact of a performance based reimbursement pilot in Chogoria, Kenya, to develop plans for expanding the scheme to all clinics, and to train CHD supervisors to train rural clinic staff.
Nov-98	Esguerra, Octavino	STTA Report	To work with the AFS Project and HMS to determine actuarial viability of a preferred provider network of health providers in Kenya
Oct-99	Esguerra, Octavino	STTA Report	To complete the pricing of a PPO based insurance product to be launched in the Kenyan market by HMS
Oct-97	Fishbein, Leslie	STTA Report	Assessment of financial and workload information systems for the MoH Cost Sharing Program (**Report on file at AFS office)
May-97	Fox, John	STTA Report	Health sector decentralization: A Kenyan framework; Report of a workshop held at the Mayfair Court Hotel, April 3, 1997
Jun-97	Fox, John	STTA Report	Health sector decentralization in Kenya: A consideration of key issues; Report of a workshop held at Lenana House, June 20, 1997
Apr-99	Fujisaki, Tomoko and Shirley Ko, Maria Pia Sanchez	STTA Report	Costing the maternity services at Coast Provincial General Hospital
Apr-99	Gichanga, Bedan		To assist co-directors of AFS costing course to prepare and conduct specific sessions on clinics costing (**No report; Prepared training materials included in the course)

Oct-98	Gikonyo, B.W.	STTA Report	Assessment and Feasibility Study for Improving Clinical Laboratory Services at Nandi Hills Sub District Hospital and Tea Estates Dispensaries Nandi Hills
Jun-99	Grant, Edward	STTA Report	To establish a hospital board based utilization management program to manage resource consumption (Draft interim report)
Oct-97	Kibiriti, Iraki	STTA Report	A comprehensive and integrative approach to management training
Aug-98	Kibiriti, Iraki	STTA Report	Installation of cash registers at Coast Provincial General Hospital
Nov-98	Kithinji, Helena	STTA Report	Preparation, Facilitation, and Write-up of a Workshop for Designing a Clinic Sustainability Strategy for the Family Planning Association of Kenya
Dec-98	Kithinji, Helena	STTA Report	Draft workshop report: Workshop on the sustainability of clinics (FPAK)
Sep-97	Lee, Arthur	STTA Report	Feasibility study of contracting options and organizational arrangements between the MoH/Thika District Hospital and AAR
Sep-99	Lim, Yen	STTA Report	To discuss contractual issues related to proposed amendment with USAID and to traing the replacement for the Technical Logistics Coordinator
Feb-00	Lim, Yen and Caroline Min	STTA Report	To negotiate a contract extension beyond the current September 2000 project end date
Sep-99	Mbiti, Daniel	Report	Desk Review of the 1993-1998 Health and Financing Plan of the MoH
Mar-97	Munar, Wolfgang	STTA Report	To assist in the start-up of the AFS Project
Mar-97	Munar, Wolfgang	STTA Report	To provide technical assistance to the Health Reform Secretariat and also the Division of Health Care Financing of the MoH on health care decentralization (Sections 1&2)
Apr-99	Musau, Stephen		To assist co-directors of AFS costing course to prepare and conduct specific sessions on clinics costing (**No report; Prepared training materials included in the course)
Oct-98	Musau, Stephen and Charles Onoka, Joseph Murage	STTA Report	Cost analysis for FPAK
Jun-98	Musau, Stephen and Samuel Kimani	STTA Report	Cost analysis for PCEA Chogoria Hospital
Oct-98	Mwangi, Jacob	STTA Report	Key financial services and other information on selected NGO's in Kenya
Aug-99	Newbrander, William	STTA Report	(1) Supervisory visit, (2) Assess progress of project against targets and indicators, (3) Review the possibility of an extension
Jan-98	Newbrander, William	STTA Report	(1) Supervisory visit, (2) Support the technical assessment by the COP and CTA of the Nandi Hills Tea Growers Association
Mar-99	Newbrander, William and Elizabeth Lewis	STTA Report	To prepare the costing course to be held in Nairobi, April 1999; To develop hospital cost model
Nov-98	Ngaine, Stanley	STTA Report	To conduct financial projections under 2 endowment mechanisms for Chogoria Hospital

Sep-98	Nganda, Benjamin	STTA Report	Monitoring and evaluation of cash registers
Jun-99	Njau, Moses	STTA Report	Report on the Assessment of District Health Management Boards
Mar-99	Njiru, Silas	Report	Ministry of Health Expenditure on Curative and Promotive and Preventive Health Care (P/PHC) and Cost Sharing
Oct-97	O'Neil, Mary	STTA Report	To develop a strategy for coordinating AFS training initiatives and scope of work for an AFS training officer
Nov-97	O'Neil, Mary	STTA Report	A training strategy for the AFS Project
Apr-98	O'Neil, Mary	STTA Report	To perform specific technical tasks related to developing and implementing training strategies for the HCFD, MOH and related NGO and private sector components
Mar-99	O'Neil, Mary	STTA Report	To perform specific technical tasks related to developing and implementing training strategies for the HCFD, MOH and related NGO and private sector components
Oct-00	Paul Krystall	Report	Extended work on FIS
May-99	Platt, Georgiana	STTA Report	Assessment of the Hospital Emergency Services Department, Coast Provincial General Hospital
Sep-97	Pollock, John	STTA Report	Capacity building within the Health Care Financing Division
Apr-98	Purvis, George	STTA Report	Technical support for feasibility of clinical laboratory and amenity ward in Nandi Hills
Jan-99	Quigley, Karen	STTA Report	To conduct assessment of the managed care potential and current strategies of Aga Khan Health Services
Jan-99	Quigley, Karen	STTA Report	To conduct assessment of the managed care potential and current strategies of Health Management Solutions
Jan-99	Quigley, Karen	STTA Report	To conduct assessment of the managed care potential and current strategies of AAR Health Services
Oct-99	Quigley, Karen	STTA Report	To complete the pricing of a PPO based insurance product to be launched in the Kenyan market by HMS
	Research International	Report	Nandi Hills Sub-District Hospital: Final Report on Main Findings
	Research International	Report	Coast Provincial Hospital: Final Report on Main Findings
	Research International	Report	Family Planning Association of Kenya: Final Report on Main Findings
	Research International	Report	Chogoria Hospital: Final Report on Main Findings
Sep-97	Sacca, Stephen	STTA Report	To perform specific technical tasks for the AFS Project related to the NGO component
Feb-98	Sacca, Stephen	STTA Report	To perform specific technical tasks in support of activities related to Mkomani clinic society, Chogoria, and FPAK
Sep-97	Sacca, Stephen and Charles Stover	STTA Report	Strategy for NGO and private sector initiatives to be carried out by the AFS Project
Sep-97	Sacca, Stephen and Charles Stover	STTA Report	Summary of findings from meetings with NGOs, insurers, employers and private providers
Sep-97	Sacca, Stephen and Charles	STTA Report	Proposed strategy for NGO and private sector initiatives

	Stover		
Nov-98	Servin, Jesus	STTA Report	Trip report: Strategy design for improving financial and managerial sustainability of FPAK clinics
Nov-98	Servin, Jesus and Juan Carlos Negrette	STTA Report	Strategy design for improving financial and managerial sustainability of FPAK clinics
Mar-00	Sliney, Ian	Report	Financial Performance of the MOH Cost Sharing Program, 1998-1999
Aug-97	Sohaili, Rostam	STTA Report	Technically assist in the organization, annotation and cataloguing of project documentation
Oct-00	Stover		Charlie Trip report- October 2000
Mar-97	Stover, Charles	STTA Report	To assist in the start-up of the AFS Project
May-97	Stover, Charles	STTA Report	To perform specific technical tasks for the AFS Project
Sep-97	Stover, Charles	STTA Report	To perform specific technical tasks related to strategies for the NGO and private sector components
Apr-98	Stover, Charles	STTA Report	To perform specific technical tasks related to strategies for the NGO and private sector components
Nov-98	Stover, Charles	STTA Report	To perform specific technical tasks for the AFS Project
Apr-99	Stover, Charles	STTA Report	To perform specific technical tasks for the AFS Project
Nov-98	Stover, Charles and Ian Sliney, William Newbrander, Jay Clark, Kalele, Ballam	Presentation	A public-private partnership in Kenya: The Nandi Hills Doctor's Scheme (presented at the 126th APHA conference, Washington, D.C.)
Jan-98	Stover, Charles and William Newbrander	STTA Report	To perform preliminary feasibility study for AFS technical support to the Nandi Hills Doctors Scheme, supported by the Nandi Hills Tea Grower Association
Jun-98	Thuo, Mike	Report	National Conference on “Strategies for Reforming the Drug and Medical Supplies Systems in Kenya”
Jun-98	Wang'ombe, Joseph	STTA Report	To act as facilitator at MSCU conference
Aug-98	Wang'ombe, Joseph and Anthony Wambugu	STTA Report	Assessment of claiming and reimbursement to Kenya Public Hospitals from National Hospital Insurance Fund (NHIF)
May-99	Warren, Richard	STTA Report	To provide direct on-site technical assistance and for successful coordination and implementation of the hospitals re-engineering plan for improving performance and quality at Coast PGH
Mar-97	Welch, Chris	STTA Report	Setup of administrative procedures for AFS Project
Nov-99	Ytterberg, Lorea	STTA Report	Assessment of the Hospital Nursing Outpatient, Inpatient, Maternity and Operating Theatre Departments: Coast PGH (November 8, 1999-February 29, 2000)
Mar-00	Ytterberg, Lorea	STTA Report	Re-engineering Hospital Nursing Services, Coast PGH: Final Report (March 1-July 31, 2000)